ACCT# _____ PATIENT INFORMATION

THE FOLLOWING INFORMATION IS NEEDED IN ORDER TO BETTER SERVE YOU. PLEASE ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY. PLEASE PRINT.

Full Name _____ Sex: M F

Home Phone _____Cell Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip Code _____

Age _____ Birth Date _____ Marital Status (Circle One) S M W D Sep Number of Children ____

SSN# _____-____-_____ Driver's License Number _____

Email Address _____

Employer _____ Occupation _____ Number of Years _____

Employer Address _____ City _____ State ____ Zip Code _____

Name of Spouse _____ Spouse Date of Birth: _____

In case of Emergency:

Name of Spouse, Parent or Guardian _____

Spouse's Employer _____ Spouse's Work Phone _____

Employer's Address _____ City _____ State ____ Zip Code _____

How did you find out about our office? _____

I (We) agree to pay for services rendered to the above mentioned patient as the charge is occurred. I (We) authorize the doctor and his staff to release any information deemed appropriated concerning my physical condition to any ins. co., attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

I (We) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtness to the assignee. I agree that a photo static copy of this agreement shall serve as the original.

**Patient Signature _____ Date _____**

**Spouse or Guardian Signature _____ Date _____**

****Notice to our new patients: Full payment for services rendered is due at the end of each visit****

# Kauffman Chiropractic
# 24-Hour Diet Recall

Please be as specific as possible. Include everything you have eaten in the past 24 hours. Include all beverages, condiments, and portion sizes.

| Time | Food Item and Method of Preparation | Amount Eaten | Where |
|---|---|---|---|
| Ex. 8AM | Hamburger | | Wendy's |
| | Beef patty | 8 oz | |
| | Bun | 2 servings | |
| | Lettuce | ½ cup | |
| | Ketchup | 1 oz | |
| | Mayo | 1 oz | |
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Is this a typical day of food for you? If not, please explain _____

_____

**Activity Level: Please Circle:**

| | | | |
|---|---|---|---|
| Sedentary: (typical daily household tasks and little physical activity at work) | Low Active: (30-60 minutes of brisk walking at least 5 days per week) | Active: (over 60 minutes brisk walking, other moderately intense activity daily) | Very Active: (Active lifestyle and 60 minutes of intense activity such as jogging per day) |

**ENTER YOUR CURRENT HEIGHT _____ AND WEIGHT _____**

# *HEALTH APPRAISAL - BRIEF*

NAME_____ DATE_____

CIRCLE the number which best describes the ***frequency*** of your symptoms. If you do not know the answer to the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the **Total Point** box. The score for YES is the number inside the parenthesis ( ).

**(0) never or rarely (1) twice a week or less (2) three to six times a week (3) daily or several times a day**

## PART I

### Section A

| | | | | |
|---|---|---|---|---|
| 1. Indigestion | 0 | 1 | 2 | 3 |
| 2. Belching, burping | 0 | 1 | 2 | 3 |
| 3. Gas immediately following a meal | 0 | 1 | 2 | 3 |
| 4. Sense of fullness during meals | 0 | 1 | 2 | 3 |
| 5. Poor appetite, picky eater | 0 | 1 | 2 | 3 |
| 6. Difficult bowel movements | 0 | 1 | 2 | 3 |
| 7. Difficulty swallowing | 0 | 1 | 2 | 3 |
| 8. History of anemia, unresponsive to iron | N | | | Y (10) |
| 9. Vegetarian (no eggs, dairy) | N | | | Y (5) |
| 10. Spoon shaped nails | N | | | Y (3) |
| 11. Unintentional weight loss | N | | | Y (3) |
| 12. Partial loss of taste or smell | N | | | Y (3) |

**Total Points**_____

### Section B

| | | | | |
|---|---|---|---|---|
| 1. Indigestion and fullness lasts 2-4 hours after eating | 0 | 1 | 2 | 3 |
| 2. Pain, tenderness, soreness on left side under rib cage | 0 | 1 | 2 | 3 |
| 3. Bloated | 0 | 1 | 2 | 3 |
| 4. Excessive passage of gas | 0 | 1 | 2 | 3 |
| 5. Abdominal cramps, aches | 0 | 1 | 2 | 3 |
| 6. Nausea and/or vomiting | 0 | 1 | 2 | 3 |
| 7. Specific foods/beverages aggravate indigestion | 0 | 1 | 2 | 3 |
| 8. Roughage and fiber causes constipation | 0 | 1 | 2 | 3 |
| 9. Three or more large bowel movements daily | 0 | 1 | 2 | 3 |
| 10. Alternating constipation and diarrhea | 0 | 1 | 2 | 3 |
| 11. Undigested food in stool | 0 | 1 | 2 | 3 |
| 12. Mucus in stool | 0 | 1 | 2 | 3 |
| 13. Dry, flaky skin, dry brittle hair | N | | | Y (3) |
| 14. Difficulty gaining weight | N | | | Y (3) |

**Total Points**_____

### Section C

| | | | | |
|---|---|---|---|---|
| 1. Stomach pain, burning, aching 1-4 hours after eating | 0 | 1 | 2 | 3 |
| 2. Feeling hungry an hour or two after eating | 0 | 1 | 2 | 3 |
| 3. Stomach discomfort, pain in response to strong emotions, thoughts, smell of food | 0 | 1 | 2 | 3 |
| 4. Heartburn, especially when lying down, bending forward | 0 | 1 | 2 | 3 |
| 5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine | 0 | 1 | 2 | 3 |
| 6. Difficulty or pain when swallowing | 0 | 1 | 2 | 3 |
| 7. Chest pain or infections, difficulty breathing | 0 | 1 | 2 | 3 |
| 8. Experience relief from carbonated beverages, cream/milk/food | 0 | 1 | 2 | 3 |
| 9. Constipation | 0 | 1 | 2 | 3 |
| 10. Black, tarry stool | 0 | 1 | 2 | 3 |

**Total Points**_____

### Section D

| | | | | |
|---|---|---|---|---|
| 1. Lower abdominal pain, cramping and/or spasms | 0 | 1 | 2 | 3 |
| 2. Lower abdominal pain relief by passing stool or gas | 0 | 1 | 2 | 3 |
| 3. Raw fruits, vegetables and stress aggravate bowel pain | 0 | 1 | 2 | 3 |
| 4. Diarrhea (loose watery stool) | 0 | 1 | 2 | 3 |
| 5. More than three bowel movements daily | 0 | 1 | 2 | 3 |
| 6. Excessive gas and bloating | 0 | 1 | 2 | 3 |
| 7. Painful, difficult,straining during bowel movements | 0 | 1 | 2 | 3 |
| 8. Hard, dry or small stool | 0 | 1 | 2 | 3 |
| 9. Extremely narrow stools | 0 | 1 | 2 | 3 |
| 10. Alternating diarrhea/constipation | 0 | 1 | 2 | 3 |
| 11. Mucus, pus in stool | 0 | 1 | 2 | 3 |
| 12. Feeling that bowels do not empty completely | 0 | 1 | 2 | 3 |
| 13. Bright red blood following bowel movement | 0 | 1 | 2 | 3 |
| 14. Anal itching | 0 | 1 | 2 | 3 |

**Total Points**_____

## PART II

### Section A

| | | | | |
|---|---|---|---|---|
| 1. Moderate to severe pain under right side of rib cage | 0 | 1 | 2 | 3 |
| 2. Abdominal pain worsens with deep breathing | 0 | 1 | 2 | 3 |
| 3. Regurgitate bitter fluid | 0 | 1 | 2 | 3 |
| 4. Bloated, full feeling | 0 | 1 | 2 | 3 |
| 5. Belching, heartburn, gas | 0 | 1 | 2 | 3 |
| 6. Fatty foods cause indigestion | 0 | 1 | 2 | 3 |
| 7. Nausea or vomiting | 0 | 1 | 2 | 3 |
| 8. Feel restless, agitated | 0 | 1 | 2 | 3 |
| 9. Unexplained itchy skin worse at night | 0 | 1 | 2 | 3 |
| 10. Stool color alternates from clay colored to normal brown | 0 | 1 | 2 | 3 |
| 11. Feeling of poor health | 0 | 1 | 2 | 3 |
| 12. Fatigue, weakness, exhaustion | 0 | 1 | 2 | 3 |
| 13. Unable to concentrate, irritable, confused | 0 | 1 | 2 | 3 |
| 14. Swollen feet and/or legs | 0 | 1 | 2 | 3 |
| 15. Easy bruising | 0 | 1 | 2 | 3 |
| 16. Feeling of extreme dryness | 0 | 1 | 2 | 3 |
| 17. Reddened skin, especially palms | 0 | 1 | 2 | 3 |
| 18. Dark urine, diminished flow | 0 | 1 | 2 | 3 |
| 19. Dry, flaky skin, hair | N | | | Y (3) |
| 20. Yellowish cast to skin, eyes | N | | | Y (3) |

**Total Points**_____

### Section B

| | | | | |
|---|---|---|---|---|
| 1. Fatigue, sluggish | 0 | 1 | 2 | 3 |
| 2. Feel cold, (i.e. hands and feet) | 0 | 1 | 2 | 3 |

**Section B** (continued)

| | | | | |
|---|---|---|---|---|
| 3. Difficult, infrequent bowel movements | 0 | 1 | 2 | 3 |
| 4. Dryness - skin, hair | 0 | 1 | 2 | 3 |
| 5. Thick, brittle nails | 0 | 1 | 2 | 3 |
| 6. Outer third of eyebrow thins | 0 | 1 | 2 | 3 |
| 7. Puffy face, hands and feet | 0 | 1 | 2 | 3 |
| 8. Swollen upper eyelids | 0 | 1 | 2 | 3 |
| 9. Eyeballs move involuntarily | 0 | 1 | 2 | 3 |
| 10. Muscles weak, cramp and/or tremble | 0 | 1 | 2 | 3 |
| 11. Slow mental processes, forgetfulness | 0 | 1 | 2 | 3 |
| 12. Slow heart beats | 0 | 1 | 2 | 3 |
| 13. Loss of appetite | 0 | 1 | 2 | 3 |
| 14. Abdominal swelling | 0 | 1 | 2 | 3 |
| 15. Unsteady gait, movements | 0 | 1 | 2 | 3 |
| 16. Lack of interest in sex | 0 | 1 | 2 | 3 |
| 17. Premenstrual tension | N | | | Y (3) |
| 18. Infertility | N | | | Y (3) |
| 19. Heavy menstrual bleeding | N | | | Y (3) |
| 20. Gain weight easily | N | | | Y (10) |
| 21. Swelling of the neck | N | | | Y (10) |
| 22. Thinning hair on scalp, face and genitals | N | | | Y (3) |

**Total Points**_____

## PART III

| | | | | |
|---|---|---|---|---|
| 1. Progressive, mild fatigue after exertion or stress | 0 | 1 | 2 | 3 |
| 2. General weakness | 0 | 1 | 2 | 3 |
| 3. Blurred vision, dizzy when rising | 0 | 1 | 2 | 3 |
| 4. Depression | 0 | 1 | 2 | 3 |
| 5. Rapid mood swings | 0 | 1 | 2 | 3 |
| 6. Irritable, nervous | 0 | 1 | 2 | 3 |
| 7. Dark circles under the eyes | 0 | 1 | 2 | 3 |
| 8. Disinterest in food | 0 | 1 | 2 | 3 |
| 9. Abdominal pain | 0 | 1 | 2 | 3 |
| 10. Indigestion | 0 | 1 | 2 | 3 |
| 11. Blotchy skin (white patches) | 0 | 1 | 2 | 3 |
| 12. Tan skin, no sun | 0 | 1 | 2 | 3 |
| 13. Black freckles on upper forehead, face, neck | 0 | 1 | 2 | 3 |
| 14. Craving for salty foods | 0 | 1 | 2 | 3 |
| 15. Gradual loss of body hair | N | | | Y (3) |
| 16. Sensitive to subtle changes in surroundings, weather | N | | | Y (5) |

**Total Points**_____

## PART IV

**Section A**

| | | | | |
|---|---|---|---|---|
| 1. Generalized bone tenderness and achiness | 0 | 1 | 2 | 3 |
| 2. Localized bone pain | 0 | 1 | 2 | 3 |
| 3. Bone deformity or swelling | 0 | 1 | 2 | 3 |
| 4. Shins hurt during or after exercises | 0 | 1 | 2 | 3 |
| 5. Low back or hip pain | 0 | 1 | 2 | 3 |
| 6. Limp, walking difficulties | 0 | 1 | 2 | 3 |
| 7. Crunching or creaking sounds when move joints | 0 | 1 | 2 | 3 |
| 8. Hands, feet, throat spasm, feel numb | 0 | 1 | 2 | 3 |
| 9. Joint pain and stiffness - especially in spine, hips, knees | 0 | 1 | 2 | 3 |
| 10. Hearing loss, headaches, ringing in ears | 0 | 1 | 2 | 3 |
| 11. Established bone loss | N | | | Y (10) |
| 12. Calcium deposits | N | | | Y (5) |
| 13. Spinal curvature | N | | | Y (10) |
| 14. Recent loss of height | N | | | Y (10) |
| 15. Bow legs | N | | | Y (5) |
| 16. Stooped posture | N | | | Y (5) |
| 17. Hump at base of neck | N | | | Y (5) |
| 18. Unexplained bone fracture | N | | | Y (10) |
| 19. Tooth loss, gum disease | N | | | Y (3) |

**Total Points**_____

**Section B**

| | | | | |
|---|---|---|---|---|
| 1. General muscle ache, pains | 0 | 1 | 2 | 3 |
| 2. Localized muscle stiffness, tension, pain | 0 | 1 | 2 | 3 |
| 3. Specific points on body feel sore when presses | 0 | 1 | 2 | 3 |
| 4. Headaches | 0 | 1 | 2 | 3 |
| 5. Fatigue, tired, sluggish | 0 | 1 | 2 | 3 |
| 6. Difficulty sleeping | 0 | 1 | 2 | 3 |
| 7. Feel unrefreshed upon awakening | 0 | 1 | 2 | 3 |
| 8. Muscle weakness or loss | 0 | 1 | 2 | 3 |
| 9. Difficulty speaking swallowing | 0 | 1 | 2 | 3 |
| 10. Muscle cramps or spasm | 0 | 1 | 2 | 3 |
| 11. Muscles twitch or tremble - eyelids, thumb, calf muscle | 0 | 1 | 2 | 3 |
| 12. Irresistible urge to move legs | 0 | 1 | 2 | 3 |

**Section B** (continued)

| | | | | |
|---|---|---|---|---|
| 13. Legs move during sleep | 0 | 1 | 2 | 3 |
| 14. Numbing, tingling sensation | 0 | 1 | 2 | 3 |
| 15. Excessive joint mobility | 0 | 1 | 2 | 3 |
| 16. Unable to fully straighten or extend legs and/or arms | 0 | 1 | 2 | 3 |
| 17. Upper or lower back pain | 0 | 1 | 2 | 3 |

**Total Points**_____

**Section C**

| | | | | |
|---|---|---|---|---|
| 1. Joint stiffness, soreness | 0 | 1 | 2 | 3 |
| 2. Red, swollen painful joints | 0 | 1 | 2 | 3 |
| 3. Joint stiffness worsens with rest, improves with moving | 0 | 1 | 2 | 3 |
| 4. Cracking joints | 0 | 1 | 2 | 3 |
| 5. Shooting, aching, tingling pain down the back of leg | 0 | 1 | 2 | 3 |
| 6. Joint pain involves one or a few joints | 0 | 1 | 2 | 3 |
| 7. Joints hurt when moving or when carrying weight | 0 | 1 | 2 | 3 |
| 8. Limited range of motion | 0 | 1 | 2 | 3 |
| 9. Difficulty standing up from sitting position | 0 | 1 | 2 | 3 |
| 10. Joint stiffness improves with rest, worsens with moving | 0 | 1 | 2 | 3 |
| 11. Headache | 0 | 1 | 2 | 3 |
| 12. Difficulty chewing food or opening mouth | 0 | 1 | 2 | 3 |
| 13. Numbness, prickling, tingling sensation in the neck, shoulder and arms | 0 | 1 | 2 | 3 |
| 14. Involuntary muscle spasms | 0 | 1 | 2 | 3 |
| 15. Deliberate movement with hands is difficult | 0 | 1 | 2 | 3 |
| 16. Injure, strain, sprain easily | 0 | 1 | 2 | 3 |
| 17. Discomfort or pain in neck, shoulder or arm | 0 | 1 | 2 | 3 |
| 18. Knobby overgrowths on the joints closest to the fingertips | N | | | Y (5) |
| 19. Double jointed | N | | | Y (5) |
| 20. One leg shorter than the other | N | | | Y (5) |

**Total Points**_____

## Medical History

- ☐ Arthritis
- ☐ Allergies/Hay Fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Autoimmune Disease
- ☐ Blood Pressure Problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic Fatigue Syndrome
- ☐ Carpal Tunnel Syndrome
- ☐ Cholesterol – Elevated
- ☐ Circulatory Problems
- ☐ Colitis
- ☐ Dental Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat Problems
- ☐ Environmental Sensitivities
- ☐ Fibromyalgia
- ☐ Food Intolerance
- ☐ Gastroesophageal Reflux Disease
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Kidney or Bladder Disease
- ☐ Learning Disabilities
- ☐ Liver or Gallbladder Disease (stones)
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Neurological Problems (Parkinson's, Paralysis)
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually Transmitted Disease
- ☐ Skin Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Tract Infection
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Headaches
- ☐ Shoulder Pain
- ☐ Hip Pain
- ☐ Foot Pain
- ☐ Varicose Veins
- ☐ Other: _____

## Medical (Men)

- ☐ Benign Prostatic Hyperplasia (BPH)
- ☐ Prostate Cancer
- ☐ Decreased Sex Drive
- ☐ Infertility
- ☐ Sexually Transmitted Disease
- ☐ Other

## Medical (Women)

- ☐ Menstrual Irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic Breasts
- ☐ Fibroids/Ovarian Cysts
- ☐ Premenstrual Syndrome (PMS)
- ☐ Breast Cancer
- ☐ Pelvic Inflammatory Disease
- ☐ Vaginal Infections
- ☐ Decreased Sex Drive
- ☐ Sexually Transmitted Disease
- ☐ Other: _____
- ☐ Age of First Period _____
- ☐ Date of last gynecological Exam_____
- ☐ Mammogram _____
- ☐ PAP _____
- ☐ Form of Birth Control
- ☐ # of Children _____
- ☐ # of Pregnancies _____
- ☐ C-Section
- ☐ Surgical Menopause
- ☐ Menopause
- ☐ Date of Last Menstrual Cycle _____

## Family Healthy History

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Infertility
- ☐ Learning Disabilities
- ☐ Mental Illness
- ☐ Mental Retardation
- ☐ Stroke
- ☐ Suicide
- ☐ Other: _____
- ☐ Migraine Headaches
- ☐ Neurological Disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis

## Health Habits

- ☐ Tobacco: Cig Chew #/day_____ #/yrs_____
- ☐ Alcohol: Wine: #/day _____ Liquor: #/day _____ Beer: #/day _____
- ☐ Water: # glasses/day ____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 min or more duration/wk
- ☐ 30-45 min duration/workout
- ☐ Less than 30 min
- ☐ Walk
- ☐ Run, Jog, Jump rope
- ☐ Weight Lift
- ☐ Swim
- ☐ Box
- ☐ Yoga
- ☐ Other: _____

## Nutrition & Diet

- ☐ Mixed food diet (animal & Veg)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt Restriction
- ☐ Fat Restriction
- ☐ Starch/Carbohydrate Restriction
- ☐ Total Calorie Restriction
- ☐ Specific Food Restrictions
- ☐ Other: _____

## Food Frequency

- ☐ Servings Per Day: _____ Fruits (Citrus, Melons, etc.)
- ☐ Dark green or deep yellow/orange vegetables _____
- ☐ Grains (unprocessed) _____
- ☐ Beans, Peas, Legumes _____
- ☐ Dairy, Eggs _____
- ☐ Meat, Poultry, Fish _____

## Eating Habits

- ☐ Skip breakfast
- ☐ Two meals/days
- ☐ One meal/day
- ☐ Graze (small frequent meals)
- ☐ Food Rotation
- ☐ Eat constantly (hungry or not)
- ☐ Eat on the run
- ☐ Add Salt to food
- ☐ Current Supplements
- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/ GLA
- ☐ Calcium, source
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive Enzymes
- ☐ Amino Acids
- ☐ CoQ10
- ☐ Antioxidants (eg. Lutein, resveratrol, etc)
- ☐ Herbs – teas
- ☐ Herbs – extracts
- ☐ Homeopathy
- ☐ Protein Shakes
- ☐ Super foods (eg. Phytonutrient blends)
- ☐ Liquid Meals
- ☐ Other: _____

## Would you like to:

- ☐ Have more Energy
- ☐ Be Stronger
- ☐ Have more Endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly, be more focused
- ☐ Improve memory
- ☐ Do better on tests
- ☐ Not be dependent on over-the counter meds (aspirin, ibuprofen, sleeping aids, etc)
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have stronger teeth
- ☐ Get less colds and flu's
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (eg. Cancer, heart disease, etc)

**Please list all of your current medications and supplements**

| MEDICATIONS / SUPPLEMENTS | DOSAGE |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
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| 19. | |
| 20. | |

**Please return your completed intake forms to Kauffman Chiropractic at least 24 hours before your scheduled appointment.**

**3 OPTIONS**

1. **Email to kauffman@kauffmanchiropractic.com**
2. **Or Fax to 513-683-6226**
3. **Or Drop Off at Kauffman Chiropractic**
   **215 Loveland-Madeira Road**
   **Loveland, OH 45140 (across from the Loveland post office)**